CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3648	**Date: November 8, 2016**
	Change Request 9794

Transmittal 3639, dated October 28, 2016, is being rescinded and replaced by Transmittal 3648, November 8, 2016, to remove the Sensitive/Controversial designation and to include the revised attachment. All other information remains the same.

SUBJECT: Calendar Year (CY) 2017 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

I. SUMMARY OF CHANGES: This instruction furnishes contractors with the information needed for the 2017 participation enrollment. The attached Recurring Update Notification applies to Chapter 1, Section 30.3.12.

EFFECTIVE DATE: October 28, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 8, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3648	Date: November 8, 2016	Change Request: 9794

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SUBJECT: Calendar Year (CY) 2017 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

EFFECTIVE DATE: October 28, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 8, 2016

I. GENERAL INFORMATION

A. Background: Contractors conduct an enrollment period on an annual basis in order to provide eligible physicians, practitioners and suppliers with an opportunity to make their calendar year Medicare participation decision by December 31. Providers (physicians, practitioners, or suppliers) who want to maintain their current PAR status (PAR or non PAR) do not need to take any action in the upcoming annual participation enrollment program. To sign a participating agreement is to agree to accept assignment for all covered services that are provided to Medicare patients. After the enrollment period ends, contractors publish an updated list of participating physicians, practitioners, and suppliers in their local MEDPARDs on their Web sites.

B. Policy: The annual participation enrollment program for CY 2017 will commence on November 14, 2016, and will run through December 31, 2016.

The purpose of this Recurring Update Notification is to furnish contractors with information needed for the CY 2017 participation enrollment effort. The following documents are attached:

- A Participation Announcement; and
- A Blank Participation Agreement.

Contractors shall mail the participation enrollment postcard as directed in Publication 100-04, Chapter 1, section 30.3.12. **Contractors shall place the new fees (physician fee schedule fees and anesthesia conversion factors) on their Web site for providers to access and download. The information contained in this Recurring Update Notification must be kept CONFIDENTIAL until the Physician Fee Schedule Final Rule is put on display. Fees should not be posted on the Web or be mailed until after the final rule is put on display.**

Contractors will not receive a Special Edition (SE) Medicare Learning Network (MLN) Matters article related to this Change Request (CR), however, be sure to post the following language on your Web site:

"We encourage you to visit the Medicare Learning Network® (MLN) (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html) the place for official CMS Medicare Fee-For-Service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html. You can also find other important Web sites by visiting the Physician Center

Web page at: http://www.cms.gov/Center/Provider-Type/Physician-Center.html , and the All Fee-For-Service Providers Web page at https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html .

In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html ."

In CR 7412 (Postcard Mailing for the Annual Participation Open Enrollment Period), CMS directed contractors to mail a postcard instead of a CD. The postcards should be mailed in time for physicians, practitioners, and suppliers to receive the participation enrollment material by November 14, but should not be mailed before November 8.

The CMS plans to release the 2017 Medicare Physician Fee Schedule File, including the anesthesia file, to contractors electronically in late October. This data must also be kept confidential until the physician fee schedule final rule is put on display. CMS will send all contractors an e-mail notice when the Physician Fee Schedule Final Rule has been put on display.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9794.1	Contractors shall mail postcards announcing the annual open participation enrollment by November 14, 2016, but not before November 8, 2016. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.		X							
9794.2	Contractors shall display the fee data prominently on their Web site. For CY 2017 disclosure reports, contractors shall use the following format for displaying fees on the Web and/or hardcopy: • Procedure code (including professional and technical component modifiers, as applicable); • Par amount (non-facility); • Par amount (facility-based);		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Non-par amount (non-facility); • Limiting charge (non-facility); • Non-par amount (facility-based); • Limiting charge (facility-based); • EHR Limiting Charge; • PQRS Limiting Charge; • EHR + PQRS Limiting Charge									
9794.3	Contractors shall provide a link to the 2017 Medicare Fee Schedule on their Web site. **NOTE:** Disclosure materials may not be posted on your Web site until you receive notification from CMS that the Physician Fee Schedule Final Rule has been put on display.		X							
9794.4	For CY 2017 disclosure reports, contractors shall provide the anesthesia conversion factors on their Web site.		X							
9794.5	Contractors shall display the fee schedule using a provider friendly format from which providers can download their particular locality. Providers should not have to download the whole fee schedule file.		X							
9794.6	Contractors shall post the following language on your Web site: *"We encourage you to visit the Medicare Learning Network® (MLN) (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html) the place for official CMS Medicare Fee-For-Service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at:*		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html. You can also find other important Web sites by visiting the Physician Center Web page at: http://www.cms.gov/Center/Provider-Type/Physician-Center.html, and the All Fee-For-Service Providers Web page at https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html . *In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html ."*									
9794.7	Effective immediately, contractors shall educate providers via their Web site and whatever other provider outreach that can be utilized that the fees will be placed on the contractor Web site after the CY 2017 physician fee schedule regulation is put on display.		X							
9794.8	Contractors shall prominently display the announcement and participation agreement on the Web site.		X							
9794.9	Contractors shall insert their Web site address for providers to use to access the CY 2017 payment rates in the space available at the end of the Participation Announcement sheet.		X							
9794.10	Contractors shall insert their contractor-specific information (i.e., toll-free telephone numbers, etc.) in the blank lines as indicated at the end of the Participation Announcement sheet.		X							
9794.11	Contractors shall inform providers via their listserv		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	when the CY 2017 fees are posted to their Web site**.**									
9794.12	Contractors shall **NOT** produce hard copy disclosures until you receive notification from CMS. **NOTE**: When notified, contractors have the discretion to produce no more than 2 percent hardcopy if needed.		X							
9794.12.1	Contractors shall keep track of any requests for hard copy paper disclosures.		X							
9794.12.2	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.		X							
9794.12.3	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.		X							
9794.13	The MPFSDB will contain the CY 2017 fee schedule amounts. Contractors shall include fee amounts for procedure codes with status indicators of A, T, and R (if Relative Value Units (RVUs) have been established by CMS). The following statements must be included on the fee disclosure reports: “All Current Procedural Terminology (CPT) codes and descriptors are copyrighted 2016 by the American Medical Association.” “These amounts apply when service is performed in a facility setting.” (This statement should be made applicable to those services subject to a differential based on place of service.) “The payment for the technical component is capped at the OPPS amount.” (This statement should be made applicable to services in which the technical portion was capped at the Outpatient Prospective Payment System amount.) "Limiting Charge reduced based on the EHR Negative adjustment program." "Limiting Charge reduced based on the PQRS Negative adjustment program." "Limiting Charge reduced for EPs that are subject to		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	both EHR and PQRS Negative adjustment program." See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1.									
9794.14	If contractors choose to use code descriptors on their Web site, they must use the short descriptors contained in the Healthcare Common Procedure Coding System (HCPCS) file and the MPFSDB. If contractors find descriptor discrepancies between these two files, use the HCPCS file short descriptor. **NOTE**: The CMS has signed agreements with the American Medical Association regarding use of CPT, and the American Dental Association regarding use of Current Dental Terminology (CDT), on Medicare contractor Web sites, CD-ROMs, bulletin boards, and other electronic communications (refer to the IOM Publication 100-04, Chapter 23, section 20.7).		X							
9794.15	Contractors shall process participation elections and withdraws post-marked before January 1, 2017.		X							
9794.16	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2017 without regional office prior authorization and advanced approved funding for this purpose.		X							
9794.17	If contractors receive inquiries from a customer who does not have access to the contractor Web site, they shall ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via phone or letter.		X							
9794.18	Contractors shall load their local MEDPARD information for providers on their Web site within 30 days following the close of the annual participation enrollment process.		X							
9794.19	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.		X							
9794.20	Contractors shall also inform hospitals and other organizations (i.e., Social Security offices, area Administration on Aging offices, and other		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	beneficiary advocacy organizations) how to access MEDPARD information on your Web site.									
9794.21	Contractors shall make sure that the Form CMS-460 is readily available on their web sites in order for their providers to complete needed information and download for their use.		X							
9794.21.1	Contractors shall allow providers to enter all required information (except for the signature and effective date in item 2) before printing. Then, the provider will only have to print out the Form CMS-460, sign it, and mail it to the contractor.		X							
9794.22	Contractors shall protect all parts of the Form CMS-460 that do not require data entry from being altered. (The provider can only be allowed to enter their required information, and not change any other parts of the Form CMS-460).		X							
9794.23	Contractors shall continue to plug-in the January 1, (appropriate year), effective date in item 2 of the Form CMS-460 included on your web site.		X							
9794.24	Contractors shall refer to the IOM Pub. 100-04, Chapter 1, section 30.3.12.1 for more information about the postcard mailing and Web site.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Mark Baldwin, 410-786-8139 or Mark.baldwin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

Announcement
About Medicare Participation for Calendar Year 2017

We wish to emphasize the importance and advantages of being a Medicare participating (PAR) provider, and we are pleased that the favorable trend of participation continued into 2016 with a participation rate of 97.2 percent. As you plan for 2017 and become familiar with the coming changes, we hope that you will continue to be a PAR provider or, if you are non-participating (Non-PAR), will consider becoming a PAR provider.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program, which replaces the flawed Sustainable Growth Rate (SGR), will equip clinicians with the tools and flexibility to provide high-quality, patient-centered care. With clinicians as partners, the Administration is building a system that delivers better care, one in which clinicians work together and have a full understanding of patients' needs, Medicare pays for what works and spends taxpayer money more wisely, and patients are in the center of their care, resulting in a healthier country. The Quality Payment Program policy will reform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system. To be successful in the long run, the Quality Payment Program must account for diversity in care delivery, giving clinicians options that work for them and their patients. Additional information about the Quality Payment Program can be found below in this announcement.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, practitioners and suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2017 Medicare participation decision by December 31, 2016. Providers who want to maintain their current PAR status or Non-PAR status do not need to take any action during the upcoming annual participation enrollment period. To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2017. The overwhelming majority of physicians, practitioners and suppliers have chosen to participate in Medicare. During CY 2016, 97.2 percent of all physicians and practitioners are billing under Medicare participation agreements.

If you participate and bill for services paid under the Medicare physician fee schedule (MPFS), your Medicare fee schedule amounts are 5 percent higher than if you do not participate. Your Medicare

Administrative Contractor (MAC) publishes an electronic directory of providers that choose to participate.

WHAT TO DO

If you choose to be a PAR physician in CY 2017:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the available blank agreement and mail it (or a copy) to each MAC to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate in CY 2017:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each MAC to which you submit claims, advising of the termination of your participation in the participating physician program effective January 1, 2017. This written notice must be postmarked prior to January 1, 2017.

We hope you will decide to be a Medicare participant in CY 2017. Please call _____ if you have any questions or need further information on participation.

The Medicare Learning Network® (MLN) offers many products on how providers and suppliers can enroll in the Medicare Program. The products include specific information for physicians and other Part B suppliers; ordering/referring providers; institutional providers; and Durable Medical Equipment, Prosthetics, Orthotics and Supplies suppliers as well as information on the electronic Medicare enrollment system, Provider Enrollment, Chain and Ownership System (PECOS). Refer to "Medicare Provider-Supplier Enrollment National Educational Products" for a list of all MLN provider-supplier products.

How Medicare is Getting Better for Doctors and Beneficiaries

Starting in 2017, Medicare will implement an important set of changes to improve how Medicare pays for primary care, care coordination, and mental health care. Clinicians will be compensated for spending more time with their patients, serving their patients' needs outside of the office visit, and better coordinating care. These changes will deliver improved health outcomes that matter to the patient. With these changes, Medicare continues to move toward a health care system that encourages teams of clinicians to work together and collaborate in order to provide more personalized care for their patients. For more information about these new codes and other changes for 2017 see here.

In addition, Medicare is laying the groundwork to expand access to the Medicare Diabetes Prevention Program (MDPP) model starting in 2018. The model has shown clear short-term benefits to the health of beneficiaries and the Medicare program from these commonsense improvements. For the long term, we know that fewer people with diabetes also saves patients and Medicare money because they use fewer expensive prescription drugs and have fewer hospital visits. And most importantly, by

preventing diabetes, patients and families across the country can avoid suffering from a debilitating disease. That's why we are expanding the model to make it available to all eligible Medicare beneficiaries.

In the Diabetes Prevention Program Model, Medicare beneficiaries at high risk for developing diabetes are provided strategies to increase their physical activity, control their weight and decrease their risk of type 2 diabetes. These interventions have been shown to lead to a 5 percent reduction in weight and will save Medicare an estimated $2,650 for each person enrolled over a 15-month period, more than enough to cover the cost of the program.

New Data Reporting Requirement for the Clinical Laboratory Fee Schedule

On June 23, 2016, CMS released the "Medicare Clinical Diagnostic Laboratory Tests Payment System" final rule, requiring laboratories performing clinical diagnostic laboratory tests to report the amounts paid by private payors for tests on the Clinical Laboratory Fee Schedule (CLFS). For the system's first year, laboratories, including physician offices laboratories, are required to collect HCPCS laboratory codes, associated private payor rates, and volume data from the period of January 1, 2016 through June 30, 2016 and report it to CMS by March 31, 2017, if they:

- Have more than $12,500 in Medicare revenues from laboratory services on the CLFS during the data collection period and
- Receive more than 50 percent of their Medicare revenues from laboratory and physician services during the data collection period.

CMS will use this data to set CLFS payment rates effective January 1, 2018. For more information, visit the CLFS PAMA Regulations webpage.

New Payment and Care Delivery Model Tests at the CMS Innovation Center:

Physicians can directly participate in health care transformation through the efforts of the CMS Innovation Center which is charged with identifying, testing, and evaluating innovative payment and service delivery models that show promise of providing better access to quality care at lower costs for beneficiaries of Medicare, Medicaid and the Children's Health Insurance Program (CHIP). The CMS Innovation Center offers opportunities for innovators working in the field to share ideas, contribute to the discussion of improvements in health care, and participate in model tests.

As of September 30, 2015 more than 61,000 providers in all 50 states, the District of Columbia, and Puerto Rico are currently participating in over 25 Innovation Center payment and service delivery model tests, serving an estimated 4.7 million beneficiaries of Medicare, Medicaid, and CHIP. Participants include states, organizations, and a broad array of health care professionals, as well as other stakeholders in the health care community. Millions of other Americans are benefiting from CMS Innovation Center quality improvement initiatives and the engagement of other payers in model tests.

The broad engagement of providers across the country in alternative payment and service delivery models is leading to improvement. Medicare per capita spending growth rates have reached historic lows, and hospital readmission rates have declined meaningfully. All alternative payment models and payment reforms that seek to deliver better care at lower cost share a common pathway for success. Providers, payers, and others in the health care system must make fundamental changes in their day-to-day operations that improve quality and reduce the cost of health care.

This work aligns with the goals the Department of Health and Human Services (HHS) set in January of 2015 of tying 30 percent of traditional, or fee-for-service (FFS), Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. In March of 2016, President Obama announced that HHS had met its 30 percent target 11 months ahead of schedule. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as physician value-based payment modifier (VM).

We encourage providers to join the Health Care Payment Learning and Action Network that brings together private payers, providers, employers, state partners, consumer groups, individual consumers, and many others to accelerate the transition to alternative payment models. If you would like to join the Network, please complete the online form.

We also encourage you to visit the CMS Innovation Center website for further information and for announcements of new opportunities including large scale transformation of clinical practices to accomplish our aims of better care and better health at lower costs.

Medicare Shared Savings Program:

Currently, over 400 ACOs participate in the Medicare Shared Savings Program (Shared Savings Program). When an ACO succeeds in both delivering high-quality care and lowering growth in Medicare spending on patients its providers serve, it may share in the savings it achieves for the Medicare program. In performance year 2015, we shared more than $645 million in savings with 119 ACOs. ACOs that reported quality in both 2014 and 2015 improved on 84 percent of the quality measures that were reported in both years. The average quality performance improved by over 15 percent between 2014 and 2015 for four measures: screening for risk of future falls, depression screening and follow-up, blood pressure screening and follow-up, and providing pneumonia vaccinations. Over 91 percent of ACOs in a second or third performance year during 2015 increased their overall quality performance score through Quality Improvement Reward points in at least one of four quality measure domains.

When a Shared Savings Program ACO successfully reports required quality measures through the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) web interface, eligible professionals (EPs), (i.e. physicians and other practitioners) that bill under the Tax Identification Number (TIN) of an ACO participant will be deemed eligible to avoid the PQRS payment adjustment, will have their Clinical Quality Measure (CQM) reporting requirements satisfied for the Medicare Electronic Health Record (EHR) Incentive Program if they extract the data necessary for the ACO to satisfy the quality reporting requirements from certified EHR technology ***and*** the EPs

meet all other requirements of the Medicare EHR Incentive Program; and will avoid the automatic downward adjustment under the Value-Based Payment Modifier (Value Modifier) and may be eligible for upward adjustments under the Value Modifier based on the ACO's quality performance. For more information on how to access Quality and Resource Use Reports (QRURs), please refer to the QRUR section of this letter.

We encourage you to consider joining or forming an ACO under the Shared Savings Program. We also encourage physicians and other practitioners to collaborate with ACOs in your area so that together they can achieve the goals of the Shared Savings Program including successful reporting and performance on quality measures.

Please visit the Shared Savings Program webpage for more information about the program including how to apply, join or learn about ACOs in your area.

Moving From a Patchwork of Quality Programs

On December 31, 2018, three CMS quality programs: the Physician Quality Reporting System, the Medicare EHR Incentive Program and the Value-Based Payment Modifier program will end. The Quality Payment Program, which is a part of the bipartisan MACRA legislation, will transition the way clinicians are paid- from a system where payments are based on volume to payments based on quality- with the ultimate goal in mind of better care, smarter spending, and healthier beneficiaries.

To wrap-up reporting for the existing programs, clinicians should be aware of the following 2017 updates:

- There is still time to successfully report quality measures for 2016 to avoid the 2018 negative 2% PQRS payment adjustment. The 2016 reporting period ends December 31, 2016 with submission beginning January 1, 2017.
- All 2016 quality data reported under PQRS, including Qualified Clinical Data Registries (QCDR) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS data, are available for public reporting on Physician Compare in late 2017. Learn more about public reporting by visiting the Physician Compare Initiative page or contacting the Physician Compare support team at PhysicianCompare@Westat.com.

Introducing the Quality Payment Program:

In April 2015, an overwhelmingly bipartisan Congress passed MACRA. MACRA ended the SGR and its potential payment cliffs, and created a new, streamlined Medicare payment system that supports and rewards quality care for clinicians. CMS named this new payment system the **Quality Payment Program** and created a website to help clinicians learn about this new program.

Who's in the Quality Payment Program?

You're a part of the Quality Payment Program if you bill Medicare more than $30,000 a year **and** provide care for more than 100 Medicare patients a year. In addition, you must be a physician,

physician assistant, nurse practitioner, clinical nurse specialist, or a certified registered nurse anesthetist to be in the program. If it is your first year participating in Medicare, then you're not in the Quality Payment Program. CMS will be providing additional support to help you determine your eligibility soon.

When does the Quality Payment Program start?

The first performance year of the Quality Payment Program begins in 2017 and it will affect payments starting in 2019. The Quality Payment Program replaces PQRS, the EHR Incentive Program (also known as Medicare Meaningful Use), and the Value-based Payment Modifier. You will no longer need to submit information for PQRS and the Medicare EHR Incentive Program after 2016. Beginning January 1, 2017, clinicians may participate in the Quality Payment Program through one of two tracks:

- **Advanced Alternative Payment Models (APMs),** which are care organizations or approaches that let practices earn more for taking on some risk related to their patients' outcomes. You may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM. To qualify for the 5% incentive payment, you must receive at least 25% of Medicare covered professional services or see at least 20% of your Medicare patients through an Advanced APM in 2017. Examples of Advanced APMs include Medicare Shared Savings Program Track 2 and 3. A full list of Advanced APMs is available here.

- **The Merit-based Incentive Payment System (MIPS),** which gives you the opportunity to be paid more for better care and investments that support patients. In the first year, you may earn as much as a 4% payment adjustment for participating in MIPS by submitting evidence-based and practice-specific quality data. If you do not submit any information to MIPS and do not qualify for the 5% incentive payment through an Advanced APM, then you will receive a 4% negative payment adjustment in 2019. You must submit 2017 information by March 31, 2018 to earn the positive payment adjustment. Learn more about MIPS and the information available to submit here.

If you belong to a practice with 15 or fewer clinicians, then you will soon be eligible to receive free, on-the-ground help from a local organization. We're listening and want your input on how to improve the Quality Payment Program. Email us at qpp@cms.hhs.gov or call 1-866-288-8292 weekdays from 8 AM to 8 PM ET. Together, we're moving towards a modern Medicare that supports better patient care through smarter spending for a healthier America.

Availability of the 2015 Annual and Supplemental Quality and Resource Use Reports (QRURs):

We encourage all groups and solo practitioners nationwide to access their 2015 Annual QRUR which were made available in September 2016, to learn about their 2017 Value Modifier payment adjustment and performance on quality and cost measures. These QRURs are also available for groups and solo practitioners that participated in the Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2015. The 2015 Annual QRURs show how groups and solo practitioners, as identified by their Medicare-enrolled TIN, performed in 2015 on the quality and cost measures used to calculate the 2017 Value Modifier. For physicians in TINs who are subject to the 2017 Value Modifier, the QRUR shows how the Value Modifier will apply to physician payments

under the MPFS for physicians who bill under the TIN in 2017. Detailed information about the Annual QRURs is available on the 2015 QRUR and 2017 Value Modifier website.

In October 2016, CMS made available the 2015 Supplemental QRURs. These QRURs are confidential feedback reports provided to group practices with cost information on the management of their Medicare (FFS) patients based on 23 episodes of care ("episodes") that include 9 major acute condition episode types and 14 major procedural episode types. The Supplemental QRURs are for informational purposes only and complement the per capita cost and quality information provided in the Annual QRURs. Information contained in the Supplemental QRURs is not used in the Value Modifier Program and does not impact payment. Detailed information about the Supplemental QRURs is available on the Supplemental QRUR website.

The Annual and Supplemental QRURs are available here and can be accessed by an authorized representative of the TIN using an Enterprise Identity Management (EIDM) account with the correct role. Please see the How to Obtain a QRUR website for instructions on how to set up an EIDM account and access your TIN's QRURs.

Medicare and Medicaid EHR Incentive Programs:

In 2016, EPs will use EHR technology certified to the 2014 Edition or if available may use EHR technology certified to the 2015 edition or a combination of both to meet the objectives and measures of meaningful use as modified in a recent final rule[1], which includes alternate exclusions for EPs scheduled to be in Stage 1. We are proposing EPs will have a 90-day EHR reporting period within CY 2016 and attest between January 3through February 28, 2017. For more information about the EHR Incentive Programs, including the 2016 definition of meaningful use, visit the EHR Incentive Programs website.

In order to align programs and reduce the burden on physicians and other eligible professionals, physicians may submit CQM data for both the Medicare EHR Incentive Program and the PQRS program electronically.

Physicians who fail to demonstrate meaningful use for the applicable EHR reporting period may be subject to a payment adjustment to their Medicare claims. In 2017, the result will be payment of 97% of the MPFS amount. Physicians must successfully demonstrate meaningful use every year to avoid the Medicare payment adjustments. Successful demonstration of meaningful use for an EHR reporting period in 2016 will enable physicians to avoid the payment adjustment in 2018. Physicians also have the option of filing a significant hardship exception application by July 1, 2017. Don't wait until the last minute to meet meaningful use or file a hardship exception!

For more information on CMS Quality Programs:

PQRS webpage

[1] Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule, 80 Fed. Reg. 62,762 (Oct. 16, 2015).

Medicare EHR Incentive Program webpage

Value-Based Payment Modifier webpage

Social Security Number Removal Initiative (SSNRI):

The MACRA, requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions, such as claims, eligibility status, and claim status. Look at your practice management systems and business processes and determine what changes you need to make to use the new MBI. You'll need to make those changes and test them by April 2018, before we send out new Medicare cards. If you use vendors to bill Medicare, you should contact them to find out about their MBI practice management system changes. Visit our SSNRI webpage for more information.

Information Related to Medicare Prescription Drug (Part D) Coverage:

Prescriber Enrollment in Medicare

Physicians and EPs who write prescriptions for Part D drugs should be enrolled in Medicare in an approved status or have a valid record of opting out of Medicare. Any physicians and EPs not in compliance with these requirements should enroll now. The current enforcement date of the prescriber enrollment requirement is February 1, 2017. While CMS is committed to the implementation of the prescriber enrollment requirements, CMS also recognizes the need to minimize the impact on the beneficiary population and ensure beneficiaries have access to the care they need. To strike this balance, CMS will implement a multifaceted, phased approach which will align full enforcement of the Part D prescriber enrollment requirements with other ongoing CMS initiatives. Full enforcement of the Part D prescriber enrollment requirement is January 1, 2019.

Providers may enroll by completing an Internet-based PECOS application or they may complete and submit a CMS-855O application (allows the physician to enroll in Medicare to order and certify services and items, and to prescribe Part D drugs; however, this option does not confer billing privileges). Providers who wish to opt-out of Medicare may submit an opt-out affidavit to their MAC.

If you are unsure if you are compliant with this requirement, please review the prescriber enrollment file located here. The file identifies those providers who are currently in compliance with the prescriber enrollment requirements.

As part of the enrollment process, provider credentials and eligibility are verified.

- If you haven't enrolled, please do so and encourage your colleagues who are not enrolled in Medicare to enroll now. The options available for enrolling or opting out of Medicare are

identified above. Please visit the prescriber enrollment website to obtain additional information.

- Interns, residents, and fellows who are prescribers of Part D drugs may enroll in Medicare to prescribe if the state licenses these prescribers. Licensure can include a provisional license or similarly- regulated credential. Otherwise, un-licensed interns, residents, and fellows must specify the teaching physician as the authorized prescriber on the prescription. Licensed residents have the option to either enroll or use the teaching physician on claims.

- Pharmacists need not enroll or opt out for their prescriptions to be covered under Part D. More information is available by visiting Part D Prescriber Enrollment website.

NPPES Taxonomy

Please check your data in the National Plan and Provider Enumeration System (NPPES) and confirm that it still correctly reflects you as a health care provider. There is increased focus on the National Provider Identifier (NPI) as a health care provider identifier for program integrity purposes. Incorrect taxonomy data in NPPES may lead to unnecessary inquiries about your credentials as it may appear to Medicare oversight authorities that you may not be lawfully prescribing Part D drugs. Comprehensive information about how the NPI rule pertains to prescribers may be obtained here.

Prescription Drug Abuse

Prescription drug abuse is the nation's fastest growing drug problem. Additional prescriber awareness and engagement are crucial to addressing this problem. CMS has implemented an approach to help Medicare prescription drug plans identify and manage the most egregious cases of opioid overutilization, which often involves multiple prescribers and pharmacies who are not aware of each other. If you are contacted by a prescription drug plan about the opioid use of one of your patients, please take the time to provide your feedback and expertise to help assure the safe use of these products.

Prescriber Identifiers in Research

You should be aware that CMS now allows researchers to request the release of unencrypted prescriber identifiers contained in Medicare Part D data. This change in policy now gives researchers the ability to conduct important research that involves identified prescribers, which will increase the positive contributions researchers make to the evaluation and function of the Part D program. This access supports CMS's growing role as a value-based purchaser of health care, and is only granted pursuant to CMS's policies and procedures for release of such data to researchers.

Serving Qualified Medicare Beneficiaries (QMBs):

Many Medicare beneficiaries with limited incomes and resources are also covered by their state's QMB program. This means that the state Medicaid agency is responsible for these beneficiaries' Medicare cost sharing. We encourage all Medicare physicians and other practitioners to serve individuals eligible for the QMB program.

We also remind all Medicare physicians and other practitioners that they may not bill their QMB patients for Medicare cost sharing, including deductibles, coinsurance, and copayments. These rules apply to all QMB patients, including those enrolled in a Medicare Advantage (Part C) plan. Under federal law, Medicare payment plus any Medicaid payment are considered payment in full for services rendered to a beneficiary participating in the QMB program. Physicians and other practitioners may want to refresh their understanding of how their state handles QMB cost sharing claims. In most states, claims submitted to Medicare are crossed over automatically to the state Medicaid agency. States may require providers to register with their State payment system in order to receive cost sharing payments. Providers can also query their state's Medicaid eligibility verification system to identify QMBs.

Providers should make sure their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts. If they become aware of improper billing of QMBs, providers should refund any erroneous charges and recall any past or existing bills (including referrals to collection agencies) as appropriate. More information on billing procedures for QMBs is available here.

Revalidation:

CMS has met the requirements established in section 6401(a) of the Affordable Care Act (ACA) and has mailed revalidation letters to all 1.6 million providers and suppliers by the March 23, 2015 deadline. CMS is resuming regular revalidation cycles every 3 years for Durable Medical Equipment (DME) suppliers and every 5 years for all other providers and suppliers.

CMS has implemented several revalidation processing improvements to include establishing due dates by which a provider or supplier must revalidate. Revalidation due dates will fall on the last day of the month (i.e.: June 30, 2016, July 31, 2016, August 30, 2016) and are posted to https://data.cms.gov/revalidation. Providers and suppliers are expected to submit their revalidation application by this date. Generally, this due date will remain with you throughout subsequent revalidation cycles.

In addition to the posted lists, providers and suppliers will still receive email or mailed revalidation notices from their MACs when they are due to revalidate. Providers can revalidate their enrollment information using the Internet-based PECOS or the CMS-855 paper application. CMS encourages all practitioners to respond timely to revalidation requests received by their MAC. Failure to submit a complete revalidation application, including all supporting documents, may result in deactivation of your Medicare billing privileges.

For more information on the revalidation process please refer to the Revalidations website and this MLN Matters Special Edition Article.

The Medicare Learning Network® (MLN):

The MLN offers free educational materials for health care professionals on CMS programs, policies, and initiatives. Visit the MLN homepage for information on:

Publications & Multimedia

- MLN Publications offer current information on many topics such as billing, policy initiatives, and program updates.
- MLN Matters® Articles explain national Medicare policy in an easy-to-understand format and focus on coverage, billing, and payment rules for specific provider types.
- Multimedia offers videos, podcasts, and graphics that help explain the Medicare Program. Videos are also available on the YouTube MLN playlist.

Events & Training

- National Provider Calls & Events are conference calls and webcast presentations explaining new policies and changes to the Medicare Program and typically include Question & Answer sessions for participants.

- Web-Based Training Courses offer self-paced training on many topics such as coding, fraud and abuse, Medicare payment policy, and provider compliance. CMS provides continuing education credit for most courses.

Newsletter

- MLN Connects® Provider eNews is a weekly email newsletter for health care professionals containing CMS program and policy news, announcements, upcoming events, claim, pricer, and code information, and MLN updates.

Continuing Education (CE) Credit

We offer many ways to earn continuing education credit. Visit the Earn credit page for more details.

CMS is accredited to provide continuing education credit by the International Association for Continuing Education and Training (IACET) and the Accreditation Council for Continuing Medical Education (ACCME). Click here to see CMS' Accreditation Statements. In addition, many professional associations offer continuing education credit to complete training activities designed for health care professionals including physicians, nurses, billers, coders, and other clinicians. You can find a broad range of courses that focus on Medicare updates, meeting professional development goals, and state license renewal requirements.

FORM APPROVED
OMB NO. 0938-0373

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*

*List all names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC)/carrier with whom this agreement is being filed.

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. **Effective Date:** If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____.
3. **Term and Termination of Agreement:** This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
    a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
    b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant (or authorized representative of participating organization)		Date
Title (if signer is authorized representative of organization)		Office Phone Number (including area code)
Received by (name of carrier)	Initials of Carrier Official	Effective Date

INSTRUCTIONS FOR THE MEDICARE PARTICIPATING PHYSICIAN AND SUPPLIER AGREEMENT (CMS-460)

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have Medigap coverage not connected with their employment and who assign both their Medicare and Medigap payments to participants. After we have made payment, Medicare will send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

Currently, the large majority of physicians, practitioners and suppliers are billing under Medicare participation agreements.

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

- Toward the end of each calendar year, all MAC/carriers have an open enrollment period. The open enrollment period generally is from mid-November through December 31. During this period, providers who are currently enrolled in the Medicare Program can change their current participation status beginning the next calendar year on January 1. This is the only time these providers are given the opportunity to change their participation status. These providers should contact their MAC/carrier to learn where to send the agreement, and get the exact dates for the open enrollment period when the agreement will be accepted.
- New physicians, practitioners, and suppliers can sign the participation agreement and become a Medicare participant at the time of their enrollment into the Medicare Program. The participation agreement will become effective on the date of filing; i.e., the date the participant mails (post-mark date) the agreement to the carrier or delivers it to the carrier.

Contact your MAC/carrier to get the exact dates the participation agreement will be accepted, and to learn where to send the agreement.

WHAT TO DO DURING OPEN ENROLLMENT:

If you choose to be a participant:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement (CMS-460) and mail it (or a copy) to each carrier to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each carrier to which you submit claims, advising of your termination effective the first day of the next calendar year. This written notice must be postmarked prior to the end of the current calendar year.

WHAT TO DO IF YOU'RE A NEW PHYSICIAN, PRACTITIONER OR SUPPLIER:

If you choose to be a participant:

- Complete the blank agreement (CMS-460) and submit it with your Medicare enrollment application to your MAC/carrier.
- If you have already enrolled in the Medicare program, you have 90 days from when you are enrolled to decide if you want to participate. If you decide to participate within this 90-day timeframe, complete the CMS-460 and send to your MAC/carrier.

If you decide not to participate:

- Do nothing. All new physicians, practitioners, and suppliers that are newly enrolled are automatically non-participating. You are not considered to be participating unless you submit the CMS-460 form to your MAC/carrier.

We hope you will decide to be a Medicare participant.

Please call the MAC/carrier in your jurisdiction if you have any questions or need further information on participation.

DO NOT SEND YOUR CMS-460 FORM TO CMS, SEND TO YOUR MAC/CARRIER. IF YOU SEND YOUR FORMS TO CMS, IT WILL DELAY PROCESSING OF YOUR CMS-460 FORMS.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various Medicare Administrative Contractor (MAC)/carrier contacts including the MAC/carrier medical directors, please visit the CMS web site at *http://www.cms.gov/*.